



# Flexible Spending Account (FSA) Health Care Reimbursement

Mail or fax completed form and documentation to:  
**Aetna Inc.**  
 P.O. Box 4000  
 Richmond, KY 40476-4000  
 Fax to: 1-888-238-3539 (1-888-AET-FLEX)  
 Member Services: 1-800-348-3666  
 For the hearing impaired, call 1-877-703-5572 TDD/TTY

**\*\*\* You must sign and date this form to avoid claim payment delay. \*\*\***

**\*\*\* Refer to Instructions on reverse side. \*\*\***

## 1. Employee Information

Employee's FSA Identification Number <b>W</b>	Employee's Last Name	First	MI	Daytime Telephone Number ( ) -
Street Address		City	State	Zip Code

## 2. Employer Information

Employer Name <b>MONTGOMERY COUNTY</b>	FSA Control Number <b>468596</b>
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## 3. Expense Information

Patient's First Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /
Date(s) of Service (MM/DD/YYYY) From / / Thru / /		<b>Total Amount Submitted \$</b>

Patient's First Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /
Date(s) of Service (MM/DD/YYYY) From / / Thru / /		<b>Total Amount Submitted \$</b>

Patient's First Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /
Date(s) of Service (MM/DD/YYYY) From / / Thru / /		<b>Total Amount Submitted \$</b>

Patient's First Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /
Date(s) of Service (MM/DD/YYYY) From / / Thru / /		<b>Total Amount Submitted \$</b>

## 4. Orthodontia Expenses – Read Section 4 on the reverse side of this form before completing this section.

Patient's First Name	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth (MM/DD/YYYY) / /
Date(s) of Service (MM/DD/YYYY) From / / Thru / /		<b>Total Amount Submitted \$</b>

## 5. Coordination of Benefits (COB)

Are you or any family members for whom you are requesting reimbursement eligible to receive benefits under any medical, dental, prescription or vision plan other than your primary coverage?

Yes – You must include copies of all EOBs.  No

## 6. Employee Certification

I certify that the expenses for which I am seeking reimbursement from the Flexible Spending Account have been incurred by me, or by an individual who qualifies as my spouse or my dependent for federal income tax purposes. I further certify that these expenses have not been reimbursed, nor shall reimbursement be sought, from any other health plan coverage, including a Health Savings Account (HSA). I also certify that I have not, and will not, claim a tax deduction or credit for these expenses on my federal income tax return, or on my state or local tax returns in violation of state or local law. I agree to submit and retain sufficient documentation for any expense for which I seek reimbursement.

Any person who knowingly and with intent to defraud files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

**Sign Here ► Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## SUBMITTING YOUR CLAIM & PREPARING YOUR CLAIM FORM

- Retain copies for your files. Claim information cannot be returned.
- Do not highlight the form or enclosed documentation. Highlighting makes scanned and faxed documents difficult to read.
- Refer to [www.aetnavigators.com](http://www.aetnavigators.com) for additional claim tips. Once in Navigator, click on the Claims & Balances link and then click on Claims. On the left side of the screen, click on Forms. Scroll down to Flexible Spending Account (FSA) and scroll to the Reimbursement section. Click on the link for Health Care and Dependent Care claim submission guidelines.

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### SECTION 1 – Employee Information

**FSA Identification Number** – As a participant with the FSA, you have been assigned a unique participant number. Your FSA ID Number is a 9 digit number preceded with a "W". If you do not know your W#, you can locate it from any one of the following sources:

- Explanation of Payment (EOP) – Paper EOPs always display your W#.
- Activity Statement – As an Aetna FSA participant you may receive an activity statement at least once a year; refer to this statement for your W#.
- Aetna Medical ID Card – If you have Aetna medical coverage, the W# displayed on your ID card is also used for your FSA.
- Member Services – Call FSA Member Services to inquire about your W#.

**Note:** If you prefer, you can use your Social Security Number in this field.

**Employee's Address** – Report an address change to your employer. To avoid misdirected claim payments, your employer must notify Aetna of your new address.

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### SECTION 2 – Employer Information

**FSA Control Number** – Your employer has been assigned a unique FSA plan number. If this form does not have that number pre-printed, you can locate this number from any one of the sources (with the exception of the Aetna Medical ID card) listed above in Section 1.

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### SECTION 3 – Expense Information

List and separate expenses by individual family members. **Attach the appropriate documentation for each expense.**

**Note:** A canceled check is not adequate documentation.

#### **If you have insurance:**

Submit the Explanation of Benefits (EOB) with your completed claim form. If the claim was denied entirely by insurance, submit the EOB *and* the documentation listed in the instructions to the right. If insurance covered at least part of the expense, you do not need to submit any other documentation with the EOB.

**Note:** If a receipt indicates that insurance is pending, this claim will be denied until the EOB is submitted.

#### **For a prescription drug claim or if you do not have insurance:**

Submit the itemized receipt or statement from the doctor/dentist/pharmacist/health care professional. This itemized receipt or statement must include:

- Name & address of doctor/dentist/pharmacist/health care professional
- Patient's name
- Date(s) of service
- Type of service
- Dollar amount charged

**Note:** Receipt from doctor/dentist/pharmacist/health care professional must clearly document the patient's financial responsibility.

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### SECTION 4 – Orthodontia Expenses

For Orthodontia claims, please follow these guidelines.

- When submitting your first orthodontia claim, you must submit the orthodontia contract (or the Aetna Orthodontia Substantiation form) from the orthodontist along with a signed Flexible Spending Account (FSA) Health Care Reimbursement form. This contract must indicate initial fee charged, estimated insurance payment, initial start date, duration of treatment and proof partial or full down payment.
- For each monthly request for reimbursement, you must submit a completed and signed claim form with an itemized bill/statement or receipt from the orthodontist. This statement/receipt must show the monthly charge consistent with the original orthodontic contract.
- Future dates of services cannot be reimbursed. IRS guidelines require services to be incurred before you can be reimbursed. A reimbursement request for a service that will occur in a subsequent plan year will be returned to you for resubmission in that plan year.

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### SECTION 5 – Coordination of Benefits (COB)

When an expense is covered under more than one health plan, all EOBs for the expense must be submitted in order to process the reimbursement.

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### SECTION 6 – Employee Certification

**You must sign and date this form to avoid claim payment delays.**